

Submitting Paper Claims (CMS 1500)

Providers may continue to submit paper claims to DHMH for claims processing, but will experience longer processing times. Paper claims are generally paid within 4-6 weeks. Providers who choose to submit paper claims must use the CMS-1500 billing form and should send the forms to:

Department of Health and Mental Hygiene
Office of Systems, Operations, and Pharmacy
Claims Processing Division
P.O. Box 1935
Baltimore, MD 21203

Instructions for Completing the CMS-1500

Waiver for Older Adults providers are required to complete certain blocks on the CMS-1500 in order to receive payment. Table 1 shows all blocks that must be completed on the CMS-1500 form to receive payment for waiver services.

Remember:

- Always use the CMS-1500.
- Use one CMS-1500 form for each waiver participant.
- Be sure that the information entered on the form is legible.
- Be sure that the information entered is correct, especially when entering your Provider Number and the recipient's Medical Assistance ID number.
- Enter all information with blue or black ink.
- **Claims must be submitted within 12 months of the date of service.**

TABLE 1: Blocks to Complete on CMS-1500 for Billing Waiver for Older Adults Services

Block #	Title of Block	Required Entry
1.	Medicare/Medicaid/CHAMPUS/CHAMP VA/Group Health Plan/FECA Black Lung/Other	Check the box for Medicaid. Also, check the appropriate box(es) for any other type(s) of insurance applicable to this claim.
2.	Patient's Name	Enter participant's last name, first name, and middle initial from the Medicaid Assistance Card (e.g., Doe, John A).
9a.	Other Insured's Policy or Group Number [Participant's Medicaid ID number]	Enter the participant's 11-digit Medical Assistance ID number as it appears on the Medical Assistance Card. The Medical Assistance ID number MUST appear here, regardless of whether the participant has other health insurance.
11.	Insured's Policy Group of FECA Number	Insert Value " K " of the Maryland Medicaid Billing Instructions, in Block 11 of the CMS-1500.
21.	Diagnosis or Nature of Illness or Injury (Relate Items 1, 2, 3, or 4 to Item 24.E. by Line)	Participants are diagnosed as Other Specified Housing or Economic Situation; enter code " V608.00. "
24A.	Date(s) of Service From MM DD YY	Enter each separate date of service as a 6-digit numeric date (e.g. 07 01 07) for month, day, and year under the " From " heading. Leave blank the space under the " To " heading. Each date of service must be listed on a separate line. Ranges of dates are not accepted on this form.
24B.	Place of Service	For each waiver service, enter the appropriate place of service code: 11 for provider's office, 12 for participant's residence, 33 for assisted living or 99 for other facility.
24D.	Procedures, Services, or Supplies CPT/HCPCS	In the block for CPT/HCPCS, enter the 5-digit Medicaid procedure code for the waiver service (e.g., W0204).
24E.	Diagnosis Pointer	In the block for Diagnosis Pointer, enter the corresponding line number from Block 21 (e.g., 1, 2, 3, or 4).
24F.	\$ Charges	Enter the total charge billed for the procedure code (not the cost per unit of service). Do not enter the maximum fee unless that amount is your usual and customary charge. If there is more than one unit of service on a line, the charge entered for this block should be the total for all units on this line.

24G.	Days or Units	Enter the number of units of service for each procedure. The number of units must be for a single device, visit, or job.
28.	Total Charge	Enter the sum of the charges shown on all lines for Block 24F.
31.	Signature of Physician or Supplier including Degree or Credentials [Degree]	Enter the date the CMS-1500 was completed or submitted. A date must be placed in this field in order for the claim to be reimbursed. Signature by the payee provider's authorized representative is optional. Signature by physician or supplier should include degree or credentials.
33.	Provider's Billing Name, Address, Zip Code, and Phone Number	Enter the name, street, city, and zip code to which the claim may be returned.
33a.	Provider's Medicaid Provider Number [National Provider Identifier]	Your 9-digit provider number to which payment is made <u>MUST</u> be prefixed with a '5' in order for the claim to be reimbursed (e.g., 5012345678).
33b.	Provider's Medicaid Provider Number	Your 9-digit provider number to which payment is made <u>MUST</u> be prefixed with a '1D' in order for the claim to be reimbursed (e.g., 1D012345678).

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Required field #1: check all that apply to claim

DO NOT imprint, type or write any information here!!
Maryland Medicaid uses this area to print the invoice control number (ICN). This is vital to processing your claim.

PICA		PICA	
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK/LUNG OTHER (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (IC)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE MM DD YY SEX M F		7. INSURED'S ADDRESS (No., Street)	
5. PATIENT'S ADDRESS (No., Street)		8. PATIENT STATUS Single Married Other	
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other		11. INSURED'S POLICY GROUP OR FECA NUMBER	
CITY STATE		CITY ZIP CODE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		12. INSURED'S DATE OF BIRTH MM DD YY SEX M F	
10. OTHER INSURED'S POLICY OR GROUP NUMBER		13. EMPLOYER'S NAME OR SCHOOL NAME	
11. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F		14. INSURANCE PLAN NAME OR PROGRAM NAME	
12. EMPLOYER'S NAME OR SCHOOL NAME		15. RESERVED FOR LOCAL USE	
13. INSURANCE PLAN NAME OR PROGRAM NAME		16. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d	
14. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM		17. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
15. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		16. SIGNED DATE	
17. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		18. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
19. NAME OF REFERRING PROVIDER OR OTHER SOURCE		20. HOSPITALIZATION DATE MM DD	
21. RESERVED FOR LOCAL USE		22. PRIOR AUTHORIZATION NUMBER	
23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		24. DATE(S) OF SERVICE FROM TO MM DD YY MM DD YY	
24. A. DATE(S) OF SERVICE FROM TO MM DD YY MM DD YY		25. B. PLACE OF SERVICE EMG	
25. B. PLACE OF SERVICE EMG		26. C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
26. C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		27. D. DIAGNOSIS POINTER	
27. D. DIAGNOSIS POINTER		28. F. CHARGES	
28. F. CHARGES		29. G. DAYS OR UNITS	
29. G. DAYS OR UNITS		30. H. ICD-9-CM	
30. H. ICD-9-CM		31. I. ID. QUAL.	
31. I. ID. QUAL.		32. J. RENDERING PROVIDER ID. #	
32. J. RENDERING PROVIDER ID. #		33. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	
33. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		34. PATIENT'S ACCOUNT NO.	
34. PATIENT'S ACCOUNT NO.		35. ACCEPT ASSIGNMENT? YES NO	
35. ACCEPT ASSIGNMENT? YES NO		36. TOTAL CHARGE \$	
36. TOTAL CHARGE \$		37. AMOUNT PAID \$	
37. AMOUNT PAID \$		38. BILLING PROVIDER INFO & PH #	
38. BILLING PROVIDER INFO & PH #		39. BILLING PROVIDER ID QUALIFIER followed by the 9 digit Medicaid Provider #	
39. BILLING PROVIDER ID QUALIFIER followed by the 9 digit Medicaid Provider #		40. BILLING PROVIDER NPI#	
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